

Health History Form

Email: _____ Today's Date: _____

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name:			Home Phone: <i>Include area code</i>	Business/Cell Phone: <i>Include area code</i>
<i>Last</i>	<i>First</i>	<i>Middle</i>	()	()
Address:			City:	State: Zip:
<i>Mailing address</i>				
Occupation:			Height:	Weight:
			Date of Birth:	Sex: M F
SS# or Patient ID:	Emergency Contact:	Relationship:	Home Phone: <i>Include area code</i>	Cell Phone: <i>Include area code</i>
			()	()
If you are completing this form for another person, what is your relationship to that person?				
<i>Your Name</i>		<i>Relationship</i>		
Do you have any of the following diseases or problems:			<i>(Check DK if you Don't Know the answer to the question)</i>	
Active Tuberculosis.....			Yes No DK	
Persistent cough greater than a 3 week duration.....			□ □ □	
Cough that produces blood.....			□ □ □	
Been exposed to anyone with tuberculosis.....			□ □ □	
If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.				

Dental Information *Please mark (X) your responses to the following questions.*

	Yes No DK		Yes No DK
Do your gums bleed when you brush or floss?.....	□ □ □	Do you have earaches or neck pains?.....	□ □ □
Are your teeth sensitive to cold, hot, sweets or pressure?.....	□ □ □	Do you have any clicking, popping or discomfort in the jaw?.....	□ □ □
Is your mouth dry?.....	□ □ □	Do you brux or grind your teeth?.....	□ □ □
Have you had any periodontal (gum) treatments?.....	□ □ □	Do you have sores or ulcers in your mouth?.....	□ □ □
Have you ever had orthodontic (braces) treatment?.....	□ □ □	Do you wear dentures or partials?.....	□ □ □
Have you had any problems associated with previous dental treatment?.....	□ □ □	Do you participate in active recreational activities?.....	□ □ □
Is your home water supply fluoridated?.....	□ □ □	Have you ever had a serious injury to your head or mouth?.....	□ □ □
Do you drink bottled or filtered water?.....	□ □ □	Date of your last dental exam:	
If yes, how often? <i>(Check one):</i> DAILY □ / WEEKLY □ / OCCASIONALLY □		What was done at that time?	
Are you currently experiencing dental pain or discomfort?.....	□ □ □	Date of last dental x-rays:	
What is the reason for your dental visit today?			
How do you feel about your smile?			

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes No DK		Yes No DK
Are you now under the care of a physician?.....	□ □ □	Have you had a serious illness, operation or been hospitalized in the past 5 years?.....	□ □ □
Physician Name: _____	Phone: <i>Include area code</i>	If yes, what was the illness or problem?	
	()		
Address/City/State/Zip:		Are you taking or have you recently taken any prescription or over the counter medicine(s)?.....	□ □ □
		If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:	
Are you in good health?.....		_____	
Has there been any change in your general health within the past year?.....		_____	
If yes, what condition is being treated?		_____	
Date of last physical exam:		_____	

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

<p><i>(Check DK if you Don't Know the answer to the question)</i></p> <p>Do you wear contact lenses? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Date: _____ If yes, have you had any complications? _____</p> <p>Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax*, Actonel*, Atelvia, Boniva*, Reclast, Prolia) for osteoporosis or Paget's disease? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia*, Zometa*, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Date Treatment began: _____</p>	<p>Do you use controlled substances (drugs)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Do you use tobacco (smoking, snuff, chew, bidis)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If so, how interested are you in stopping? Circle one: VERY / SOMEWHAT / NOT INTERESTED</p> <p>Do you drink alcoholic beverages? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If yes, how much alcohol did you drink in the last 24 hours? _____ If yes, how much do you typically drink in a week? _____</p> <p>WOMEN ONLY Are you: Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Number of weeks: _____ Taking birth control pills or hormonal replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>
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<p>Allergies. Are you allergic to or have you had a reaction to: To all yes responses, specify type of reaction.</p> <p>Local anesthetics <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Penicillin or other antibiotics <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Barbiturates, sedatives, or sleeping pills <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Sulfa drugs <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Codine or other narcotics <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>	<p style="text-align: right;">Yes No DK</p> <p>Metals _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Latex (rubber) _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Iodine _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Hay fever/seasonal _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Animals _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Food _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Other _____ <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>
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Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

<p style="text-align: right;">Yes No DK</p> <p>Artificial (prosthetic) heart valve <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Previous infective endocarditis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Damaged valves in transplanted heart <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Congenital heart disease (CHD)</p> <p style="padding-left: 20px;">Unrepaired, cyanotic CHD <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p style="padding-left: 20px;">Repaired (completely) in last 6 months <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p style="padding-left: 20px;">Repaired CHD with residual defects <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>	<p style="text-align: right;">Yes No DK</p> <p>Autoimmune disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Rheumatoid arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Systemic lupus erythematosus <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Sinus trouble <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Cancer/Chemotherapy/ Radiation Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Chest pain upon exertion <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Chronic pain <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Diabetes Type I or II <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Eating disorder <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Malnutrition <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Gastrointestinal disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>G.E. Reflux/persistent heartburn <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Thyroid problems <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>	<p style="text-align: right;">Yes No DK</p> <p>Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Hepatitis, jaundice or liver disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Fainting spells or seizures <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Neurological disorders <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If yes, specify: _____</p> <p>Sleep disorder <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Do you snore? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Mental health disorders <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Specify: _____</p> <p>Recurrent Infections <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Type of infection: _____</p> <p>Kidney problems <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Night sweats <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Persistent swollen glands in neck <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Severe headaches/ migraines <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Severe or rapid weight loss <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Sexually transmitted disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Excessive urination <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>
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Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

<p style="text-align: right;">Yes No DK</p> <p>Cardiovascular disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Angina <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Arteriosclerosis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Congestive heart failure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Damaged heart valves <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Heart attack <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Heart murmur <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Low blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Other congenital heart defects <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>	<p style="text-align: right;">Yes No DK</p> <p>Mitral valve prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Rheumatic fever <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Rheumatic heart disease <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Abnormal bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Blood transfusion <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK If yes, date: _____</p> <p>Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>AIDS or HIV infection <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p>	<p style="text-align: right;">Yes No DK</p> <p>Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK</p> <p>Name of physician or dentist making recommendation: _____ Phone: Include area code ()</p> <p>Do you have any disease, condition, or problem not listed above that you think I should know about? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK Please explain: _____</p>
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NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

Signature of Dentist: _____ Date: _____

FOR COMPLETION BY DENTIST

Comments: _____

CLINIC POLICIES

Please read each of the following policies and return this to the Office; if requested, a copy may be given to you. We ask that you adhere to these policies for your own safety as well as the safety of other patients and the clinic staff.

1. If a patient has a New Hampshire Medicaid card, please have it available at every visit.
2. Children will not be allowed in the waiting area unattended.
3. Only the patient will be allowed in the Treatment Area, unless a parent/guardian is requested by the Doctor or Hygienist.
4. **PAYMENT** is expected on the day of service.

BROKEN APPOINTMENTS

Unfortunately due to the high broken appointment rate, our policies will now be as follows:

1. The GNDC will call and attempt to confirm all appointments (usually two days prior). If we leave a message, we require a call back to confirm. If we do not receive verbal confirmation 24 hours prior to the scheduled time, **THE APPOINTMENT WILL BE CANCELED.**
2. If the GNDC attempts to confirm an appointment and the number is disconnected or unavailable, and we do not receive confirmation, **THE APPOINTMENT WILL BE CANCELED.**
3. Once a patient has three broken appointments, in order to obtain an appointment they must call the GNDC on a daily basis to check for future appointment availability.
4. If you are more than 15 minutes late for your scheduled appointment we reserve the right to reschedule to another date and time.

I have read and understand the Clinic Policies for The Greater Nashua Dental Connection, INC., and agree to adhere to these policies.

Name: _____

Date: _____

THE GNDC RESERVES THE RIGHT TO REFUSE TREATMENT TO ANY PATIENTS AND/OR ASSOCIATES WHO DISPLAY OR THREATEN UNRULY OR VIOLENT BEHAVIOR- NO EXCEPTIONS

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the "Notice of Privacy Practices" and have been provided an opportunity to review it.

Patient _____ Birthdate _____

Parent/Guardian _____

Signature _____ Date _____

APPENDIX C

SELF-DECLARATION OF INCOME REPORT
COMMUNITY DEVELOPMENT BLOCK GRANT PROGRAM
(Updated June 1, 2021)

Federal regulations require we obtain this information to document assistance is being provided to low and moderate-income households. The Participant/Guardian should complete this form indicating all persons residing within their household, regardless of whether or not they are related. The Grantee should retain this form for monthly reporting requirements as well as for on-site monitoring visits.

INFORMATION PROVIDED ON THIS FORM IS KEPT CONFIDENTIAL AND IS NOT SHARED WITH ANY OTHER AGENCIES

PARTICIPANT INFORMATION

PARTICIPANT STATUS: FAMILY INDIVIDUAL

Participant Name: _____

Address: _____ City, State, Zip Code: _____

ETHNICITY (please select only one):

Hispanic or Latino

Not Hispanic or Latino

RACE (please select only one):

White

American Indian/Alaskan Native **and** White

Black/African American

Asian **and** White

Asian

Black/African American **and** White

American Indian/Alaska Native
American

American Indian/Alaskan Native **and** Black/African

Native Hawaiian/Other Pacific Islander

Other Multi-Racial: _____

HOUSEHOLD INFORMATION

i. Circle the total number of people living in your household.

ii. Circle the corresponding income level.

Household Size	(0-30%)	(31-50%)	(51-80%)	(Over 80%)
1	\$0 – 23,350	\$23,351 - \$38,400	\$38,401 - \$55,950	\$55,951 +
2	\$0 - \$26,350	\$26,351 - \$43,850	\$43,851 - \$63,950	\$63,951 +
3	\$0 - \$29,650	\$29,651 - \$49,350	\$49,351 - \$71,950	\$71,951 +
4	\$0 - \$32,900	\$32,901 - \$54,800	\$54,801 - \$79,900	\$79,901 +
5	\$0 - \$35,550	\$35,551 - \$59,200	\$59,201 - \$86,300	\$86,3001 +
6	\$0 - \$38,200	\$38,201 - \$63,600	\$63,601 - \$92,700	\$92,701 +
7	\$0 - \$40,800	\$40,801 - \$68,000	\$68,001 - \$99,100	\$99,101 +
8	\$0 - \$43,450	\$43,451 - \$72,350	\$72,351 - \$105,500	\$105,501 +

Check here if unemployed (please still circle household size)

I certify the above information is true and correct to the best of my knowledge.

Participant/Guardian: _____ **Date:** _____

(Original signature is required)